STATE OF MISSOURI
COMBINED ENROLLMENT FORM

DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF SPECIAL HEALTH CARE NEEDS (BSHCN)
DEPARTMENT OF SOCIAL SERVICES
MC+

DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
DIVISION OF SPECIAL EDUCATION - FIRST STEPS
DEPARTMENT OF MENTAL HEALTH
DIVISION OF MENTAL RETARDATION/DEVELOPMENTAL DISABILITIES

PART I ENROLLMENT APPLICATION

*COUNTY OF RESIDENCE OF PARTICIPANT	APPLICATION DATE

FIRST STEPS	SPOE	I.D. Number	☐ NEW REFERRAL ☐ ANNUAL UPDATE ☐ RE-REFERRAL ☐ OTHER:
BSHCN	Local Office	I.D. Number	☐ NEW ENROLLMENT ☐ REAPPLICATION ☐ REEVALUATION CHILD IS MEDICALLY: ☐ ELIGIBLE ☐ INELIGIBLE CHILD IS FINANCIALLY: ☐ ELIGIBLE ☐ INELIGIBLE DATE ELIGIBILITY DETERMINED: _____
MRDD	Local Office	I.D. Number	☐ NEW ENROLLMENT ☐ REAPPLICATION ☐ REEVALUATION CHILD IS MEDICALLY: ☐ ELIGIBLE ☐ INELIGIBLE CHILD IS FINANCIALLY: ☐ ELIGIBLE ☐ INELIGIBLE DATE ELIGIBILITY DETERMINED: _____
MC+ For Kids (Medicaid)	☐ NEW ENROLLMENT ☐ REAPPLICATION ☐ PENDING ☐ CURRENT ☐ N/A		

*****Ö **SECTION A. Child Information**

LAST NAME	FIRST NAME	MI	DOB	KNOWN AS (AKA)

STREET ADDRESS, APARTMENT NUMBER, P.O. BOX	CITY/TOWN	STATE	ZIP CODE	A/C	TELEPHONE #	MOTHER'S MAIDEN NAME

Child's Native Language: ☐ English ☐ Spanish ☐ Other:

Child's School District:

Ö **SECTION B. Parent/Legal Guardian Information**

1. *Name: _____

*Address: _____
Street City/Town State Zip Code

*Home Telephone: ( ) _____ *Office Telephone: ( ) _____ Other Telephone: ( ) _____

2. *Name: _____

*Address: _____
Street City/Town State Zip Code

*Home Telephone: ( ) _____ *Office Telephone: ( ) _____ Other Telephone: ( ) _____

*Native Language Spoken at Home: _____ Interpreter Needed?_____

*√ Intake Coordinator/Interviewer:	Address:	Telephone:
*√ Ongoing Service Coordinator:	Address:	Telephone:

Child's Name:_____ DOB: Date:

SECTION C. List all persons (including participant) who live in your household and provide requested information for each individual.

Name	*Relationship	*DOB	Marital Status	*Gender	*✓ Race/Ethnicity	Nationality	*Migrant/Homeless	*✓ Education Level	Preg (Y/N) # Fetuses	US Citizen (Y/N)	PCP (Y/N)	* SSN#	*DCN	Ins Y/N	X if applying for MC+
Child:					/										
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TOTAL HOUSEHOLD SIZE _____ ADJUSTED HOUSEHOLD SIZE _____ TOTAL APPLYING FOR MC+ _____

SECTION D. Income Verification

***** √ Are you or someone else in your household currently employed? ☐ YES If yes who _____ ☐ NO

*Total Household Gross MONTHLY Income: $ _____

Proof of Income was verified (check stub, letter, tax form, or written statement) by _____
Signature

If no income, how are you supported? _____

Is this month's income the same as the previous three months? ☐ YES ☐ NO

*Are you currently paying child care to maintain employment? ☐ YES ☐ NO

Is the child: Blind/Disabled? ☐ YES ☐ NO Receiving SSI? ☐ YES ☐ NO

Do you pay for care of an incapacitated adult? ☐ YES ☐ NO

Does anyone living in the household pay support payments? ☐ YES ☐ NO

Do you have any extraordinary expenses? ☐ YES ☐ NO

√ Federal Poverty Level ☐ <0 -100% ☐ <101-125% ☐ <126-133% ☐ <134-150% ☐ <151-185%
☐ <186-200% ☐ <201-250% ☐ <251-300% ☐ >301-400% ☐ >401%

COMMENTS:

Child's Name:_____ DOB: Date:

SECTION E. Medical Insurance Summary (*complete a new form for each insurance coverage*)

1. CHILD IDENTIFYING INFORMATION:

Name: D.O.B.: DCN:

Address: MO

Street City/Town Zip Code

***2. MC+ ENROLLMENT INFORMATION:**

Complete One: Current Coverage Effective Date:

Pending Application Date:

Not Financially Eligible Date of Denial:

MC+ Plan

Contact Info

Did participant lose health insurance coverage in the past 3 months?

☐ YES ☐ NO Date coverage ended:

Reason for loss of insurance:

***3. POLICYHOLDER INFORMATION:**

Name: Relationship: Telephone: ( )

Address:

Street City State Zip Code

***4. INSURANCE COMPANY INFORMATION:**

Name: Telephone: ( )

Address:

Street City State Zip Code

Check As Applicable: Is this Coverage: ____ Through Employer ____ Self Purchase ____ Union ____ HMO Policy ____ PPO Policy

***5. POLICY NUMBER:** Member/I.D. #: Group/Acct. #:

Effective date dependent will be covered under policy: End Date:

6. EMPLOYER INFORMATION:

*Name of Employer:

Address:

Street City State Zip Code

Telephone: ( ) Start Date:

7. COVERAGE INFORMATION: Check As Applicable:

A. Second Insurance Company Coverage? ☐ YES ☐ NO

B. Therapy Services Covered: ☐ OT ☐ PT ☐ Speech

C. Co-Payments? ☐ YES ☐ NO

Office Visit Amt: $ Specialist Amt: $

Emergency Room Amt: $ Other Amt: $

Prescriptions Amt: $ DME Services Amt: $

D. *Deductibles? ☐ YES ☐ NO If YES, Amt: $

E. Maximum Out of Pocket Expense $

F. Is there a pre-existing clause? ☐ YES ☐ NO

Effective Date:

G. Is there a dental plan? ☐ YES ☐ NO

Name of plan if different:

Effec. Date: Term. Date:

H. Lifetime maximum? ☐ YES ☐ NO

$ per person $ per family

I. Conditions/Exclusions:

Confirmation of Information:

(Signature) (Date)

Check One: ☐ First Steps Intake / Service Coordinator ☐ BSHCN Coordinator

☐ DFS Caseworker ☐ DMH Staff

*Indicates information entered and stored electronically at the System Point of Entry

√ Required for First Steps Application